BULLETIN

of the
MAHONING
COUNTY
MEDICAL
SOCIETY

September • 1959
Vol. XXIX • No. 9
Youngstown • Ohio

SEPTEMBER MEETING

TUESDAY, SEPTEMBER 22, 1959

ELKS CLUB

SPEAKERS

Mr. Henry J. Kannensohn, Henry J. Kannensohn Agency, Inc.

Mr. John B. Morgan, Jr. Associated Hospital Service, Inc.

Mr. Lloyd T. Stillson, Stillson & Donahay Agency, Inc.

6:00 Cocktail Hour
7:00 Dinner — $4.75
8:00 Meeting

Reservations must be made by Friday, September 18

Send your reservation and check to:

Mahoning County Medical Society
245 Bel-Park Bldg.
1005 Belmont Ave.
Youngstown 4, Ohio

●

VD CONFERENCE

Thursday, September 24 — Mural Room

Make your reservation through the Medical Society office. Watch the mail for further information.

●

OCTOBER

SIXTH DISTRICT POSTGRADUATE ASSEMBLY

Wednesday, October 21 — Warren, Ohio

OFFICERS AND COUNCIL

OFFICERS

M. W. NEIDUS, Pres. 318 Fifth Avenue
F. G. SCHLECHT, Pres.-Elect 2218 Market Street
A. A. DETESCO, Imm. Past-Pres. 2921 Glenwood Avenue

A. K. PHILLIPS, Secy. 1005 Belmont Avenue
C. W. STERTZBACH, Treas. 3610 Market Street
L. O. GREGG, Editor Dollar Bank Building

Council		Delegates	Alt. Delegates
H. P. McGREGOR	G. E. DeCICCO	P. J. MAHAR (1959)	C. C. WALES
S. W. ONDASH	P. J. MAHAR	H. P. McGREGOR (1960)	J. J. McDONOUGH
M. S. ROSENBLUM	C. E. PICHETTE	G. E. DeCICCO (1961)	R. R. FISHER
H. J. REESE	F. A. RESCH	A. RANDELL (1962)	S. W. ONDASH

Representative to the Associated Hospital Service: J. M. RANZ

Executive Secretary: H. C. REMPES, JR.

TABLE OF CONTENTS

Vol. XXIX—No. 9 **September, 1959**

ADVERTISERS' LIST

Our President Speaks

The July Bulletin of the Home Savings & Loan Company, an excellent magazine, had an interesting article on "How you get rid of $250,000.00."

"Over a life time, the average family has an income in the neighborhood of $250,000.00. When you analyze where it goes, you get these results: $58,000.00 for housing; $48,000.00 for food and drink; $36,000.00 for taxes; $26,000.00 for contributions, gifts, books and dues; $24,000.00 for family car; $16,000.00 for insurance; $12,000.00 for clothing; $12,000.00 for recreation; $12,000.00 for personal expenses; $6,000.00 for the doctor, dentist, medicines and hospital care."

Wouldn't it be wonderful if the government paid our taxes, food and housing? No one would complain then about paying the small amount for health.

M. W. Neidus, M.D.
President

BULLETIN of the Mahoning County Medical Societ

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Volume 29 **September, 1959** **Number 9**

Published for and by the Members of the Mahoning County Medical Society

EDITORIAL

VA MEDICAL CARE

One of the greatest threats to the private practice of medicine is the growing public acceptance of the Veterans Administration supplying government paid hospitals and medical care for veterans with non-service connected disabilities. According to reliable reports, approximately 85% of veterans' care goes to those disabilities having no connection with their services in the Armed Forces—at a cost to the taxpayer of about one billion dollars per year.

The Association of American Physicians & Surgeons, for many years, has advocated that the Veterans Administration Act be revised to provide for government paid medical and hospital care of veterans to those with service-connected disabilities only.

Originally, the law did not allow veterans with non-service connected disabilities to have free medical care. In the 1920's a law was passed allowing such veterans who were unable to pay the cost of private care, to be taken care of, if space was available. This privilege has been abused in many ways, and, until recently, there was no effort made to check on a patient's ability to pay.

Many V.A. hospitals have been built to accomodate the large number of patients with non-service disabilities; many unnecessarily, due to Congressmen anxious for the veterans' vote.

Another element came about after World War II, when Dean's committees were established to affiliate V. A. hospitals with medical schools and furnished consultants for patient care. Together, with this the residency program was expanded greatly. The V.A. now states it needs non-service connected cases to continue this program. There being a shortage of interns and residents in civilian hospitals, many V.A. hospitals could be closed or consolidated if only service patients were cared for and the excess resident physicians absorbed in the civilian hospitals.

There are many who feel as I do, that service connected cases should be taken care of on a home town basis. With a fee schedule similar to Medicare, it would be more acceptable to veterans and cost the taxpayer less. Indigent veterans could be taken care of locally as are other indigents.

Certainly, the situation, as it exists today, is a step towards socialized medicine, and is costing the taxpayer a lot of money unnecessarily so.

—L. O. Gregg, M.D., Editor

EXECUTIVE SECRETARY'S REPORT

DIRECTIVE 11749-AX-13: As of the date of this directive, all prescriptions written by you will be either typewritten or printed. Refusal to comply with this directive will subject you to a fine as provided by law . . . Fantastic? not at all. That such an order would be easily within the jurisdiction of any governmental agency set up to administer the practice of medicine was pointed out by Rolf Schlogell, M.D. at the 1959 AMA Public Relations Institute, held in Chicago on August 20-21. Dr. Schlogell knows of what he speaks. He is Secretary General of Kassenartzliche Bundesvereinigung (Organization of German Doctors Engaged in Health Insurance) of Cologne, Germany. The Chicago meeting was attended by Dr. L. S. Shensa, Public Relations Chairman, and by your executive secretary.

The entire morning session of the first day of the Public Relations Institute was concerned with varying aspects of socialized medicine. Dr. B. E. Freamo, Assistant Secretary (Economics) of the Canadian Medical Association, Toronto, Canada, spoke at great length about the Canadian government entrance into the field of medicine with a program for those under 16 years of age. Mr. Claude Robinson, Ph. D., Chairman of the Board Opinion Research Corporation, Princeton, New Jersey, told the doctors that they had a good product (private practice of medicine), but that, like any other good product, it must be properly merchandised in the face of mounting competition (a multitude of proposals for government control of medical care).

This puts the problem squarely in the lap of the individual physician and the county medical society. It is up to the doctor to see that the product is a good one and continues to be so. It is up to the medical society to merchandise the product through good public relations.

Where do we start? The first step might be to take a good look at the competition. Take a good look at the Forand Bill. Find out enough about it that you can tell your patients what it is all about. Informational brochures have been mailed to every member of the Mahoning County Medical Society. More are available at the society office. If you really think that you have a better product, let your patients and the general public know. That's just good merchandising.

—*Howard Rempes, Executive Secretary*

HAPPY BIRTHDAY!

Sept. 16
P. H. Fuscoe
R. G. Mossman
Sept. 17
J. Dentscheff
Sept. 18
J. A. Renner
E. R. Thomas
Sept. 21
R. G. Warnock
Sept. 23
W. J. Flynn
M. Halmos
Sept. 25
V. G. Herman
Sept. 27
R. J. Scheetz
Sept. 28
J. Nemeth
Sept. 29
D. H. Levy
Sept. 30
D. Stillson
Oct. 2
J. Dulick
Oct. 3
G. M. McKelvey
Oct. 4
G. Delfs
Oct. 5
B. Katz
Oct. 6
J. L. Calvin
Oct. 8
J. N. McCann
Oct. 9
J. F. Stotler
W. P. Young
Oct. 11
H. S. Ellison
Oct. 12
B. I. Firestone
J. R. Gillis
Oct. 13
A. Goudsmit
Oct. 14
E. L. McCune
J. H. Smith
Oct. 15
R. V. Clifford

5—FLUOROURACIL IN THE CHEMOTHERAPY OF CANCER

5-fluorouracil (5 F.U.) is one of a series of fluorinated pyrimidine compounds synthesized by Heidelberger and associates at the University of Wisconsin and by Duschinsky and Pleven of Hoffman-LaRoche. Its preparation constitutes part of a deliberate attempt to find agents which selectively interfere with the nucleic acid metabolism of malignant cells and thereby prevent their growth and multiplication. Initial studies in the laboratory showed its powerful antineoplastic activity against many transplantable malignant tumors of animals, as well as its potent inhibitory effect on the growth of many microorganisms.

In the last two years rather extensive experiences have been gained with the use of 5 F.U. in human patients with a great variety of inoperable malignant conditions. To date, approximately 60 groups of clinical investigators, notably Curreri, Ansfield and associates of the University of Wisconsin, have studied the effects of this compound. In order to be maximally effective, 5 F.U. has to be given intravenously in serial courses of treatment. Initial daily dosage is calculated according to body weight; administration is continued until moderate diarrhea, early stomatitis or leukopenia appears, but total dosage of drug per course should not exceed 105 milligrams per Kilogram. It is necessary to repeat each course of 5 F. U. after an interval of one month. Data on the initial results of the administration of 5 F. U. by the combined investigators in well over 600 patients are beginning to show the general pattern of applicability of the compound. Twenty-seven percent of the cases of carcinoma of the rectum and colon (all of them inoperable, or metastatic) showed measurable and significant decreases in the size of the tumor and/or metastates. In malignancies of the breast (most of them already resistant to endocrine manipulation) the rate of "objective responses" was 39%; in "metastatic malignancy of unknown primary" (a curious group—but clinicians accept, realistically, its existence) the percentage was 43%; and for carcinoma of the bladder, 87% (14 "objective responses" out of a total of 16 cases). The amazingly favorable percentage in the latter group may have been contributed to by the fact that an appreciable part of the 5 F.U., after its intravenous administration, is excreted without chemical alteration in the urine.

Other malignancies where 5 F.U. has been effective (but has not been administered in a large enough number of cases to warrant reporting the percentage of "objective responses") include carcinoma of the stomach, ovary, cervix, larynx and tongue, as well as hepatoma and leiomyosarcoma. Whereas 5 F.U. by itself has rarely helped patients with carcinoma of the lung, in a small series of cases a combination of this drug with X-ray therapy has produced regressions with encouraging frequency. Malignant melanoma, carcinoma of the pancreas, the head and neck (except as stated above), and of the uterus seldom respond. No favorable effect of 5 F.U. has been observed in the acute leukemias, multiple myeloma, hypernephroma, and carcinomas of the prostate and kidneys.

As a general rule, 5 F.U. is not a drug to be given to patients in the terminal stage of a malignancy. In order to provide the best opportunity for its optimally effective application, the patient should be in at least fair nutritional condition. He should never have received wide pelvic irradiation or significant amounts of nitrogen-mustard type of drugs, and there should be adequate bone marrow and at least fairly adequate liver function. All things being equal (which, of course, they never are) patients with larger tumors and/or metastatic masses are less likely to benefit than those in whom 5 F.U.

is used when the malignancies are smaller. Of course, at the present state of our knowledge and experience surgical treatment must be considered to have been administered to the limits of its applicability and presence of residual malignancy must have been proven to exist before the physician should entertain the use of 5 F.U. All patients should have knowledge of their diagnosis and of their condition, recognize the need for repeated courses of injections and willingly assume their treatment with this toxic chemotherapeutic agent, the use of which is still in the investigative stage.

The cumulative mortality from the drug alone when given in the recommended dosages and in the hands of experienced clinicians, is of the order of three to four percent, but in view of the prognosis of the individuals in the applicable group without any treatment, the administration of 5 F.U. to cooperative and suitably motivated patients with malignancies now beyond conventional therapy, may well be considered seriously. None of the investigators has claimed to have effected a "cure" with 5-fluorouracil but a significant number of treated patients are now alive and active with extended and sustained remissions.

Admittedly, the chemotherapy of cancer is still very much in its infancy. But the preliminary observations cited here with the experiences of 5-fluorouracil would appear to show that all the money and effort spent on cancer research is slowly, but surely, beginning to bear fruit.

It is a privilege to acknowledge the author's indebtedness to Dr. Fred J. Ansfield for initiating him in the use of 5-fluorouracil and for his review of this manuscript.

—*Arnoldus Goudsmit, M.D.*

PULMONARY DISEASE COURSE AT O. S. U.

Five sponsoring organizations have joined forces to offer a post-graduate course in pulmonary diseases especially for general practitioners and approved for credit by the Ohio Academy of General Practice. The course is scheduled at Ohio State University in Columbus on Friday and Saturday, September 25-26, 1959.

Sponsors are the Ohio State University College of Medicine, the Ohio State Medical Association, Ohio Trudeau Society, American Trudeau Society. and the Ohio Tuberculosis and Health Association.

Reservations for the course, accompanied by a check for $25.00 should be sent to: Harold L. Autrey, Treasurer, Ohio Tuberculosis Hospital, Columbus 10, Ohio. Registration is limited to 150 and applications must be received by September 8, 1959.

Hotel reservations should be made with the hotel of choice. The Fort Hayes Hotel has reserved a limited number of rooms until September 8, 1959. (The football weekend makes this early reservation necessary.)

An additional attraction is the Ohio State-Duke University football game on Saturday afternoon, September 26.

The registration fee includes one ticket for the banquet on Friday evening. Extra tickets at $5 each may be secured for those who wish to bring their wives.

The course has been designed to provide the physician in general practice with current concepts of pulmonary disease, cardiac surgery, and carcinoma with emphasis on practical aspects of diagnosis and treatment.

The program will be held in the Ohio Union Conference Theater, Ohio State University, High Street at 13th Avenue. The banquet will be held in the Gold Room, Fort Hayes Hotel, Columbus.

SOME ADVANTAGES OF THE USE OF TRUSTS TO THE PHYSICIAN

TRUST: "A right of property, real or personal, held by one party for the benefit of another."

This simple definition attempts to summarize one of the most interesting and complex legal concepts used in our society today. The Law of Trusts had its beginning in feudal England and, interestingly enough, the crown and church were moving forces in its development. The ecclesiastical bodies of feudal England were acquiring great wealth and power through gifts and devises of land. King Edward I by the Statute of Mortmain, 1275, attacked the title of property forever residing in these religious corporations. To avoid the Mortmain Statute the English Law devised the theory of Uses—that is to say that while legal title to property might be held by one person, its use and enjoyment would flow to another. The Statute of Uses and the Rule Against Perpetuities which are part of the Law of Trusts as we know it today eventually emerged from this feudal background. We are not concerned here with the technical aspects of Trust Law, but we are interested in how Trusts may be of value to us in our everyday family and business affairs.

The Trust was soon recognized as a useful device for protecting property against creditors, making transfers of property without public notice, and obtaining for the use of beneficiaries expert management and guidance in the conservation of family estates. The American Law has extended the benefits of the Trust to those who are financially incompetent in the form of the unique American Spendthrift Trust.

One of the great values of a Trust, and one often overlooked, is the privacy which it affords our personal affairs. While wills and estates are subject to probate and thus become a public record, the Trust is a private instrument of the creator in which he may direct in whatever detail he desires the disposition and management of his property and the terms under which his beneficiaries will enjoy that property. He may allow the Trustee discretion as to the distribution of the property in time and amount, the method of investment and management of the property, or he may severely circumscribe the actions of the Trustee by specific directions.

Chances of litigation are much reduced by the use of a Trust. The surviving spouse has dower or courtesy rights by law in the estate, or the survivor may elect against the will or bring suit (as may other heirs) to challenge the validity of the will. The intervivos trust on the other hand requires no court action to bring it into operation and all the power of the law is available through the courts to enforce and protect the rights of the beneficiaries.

There is much to be said for establishing your Trust while you are living (intervivos) for it gives you an opportunity to see how your Trustee will perform, to develop a satisfactory working relationship between the beneficiary and Trustee, to see if your plans are sound and workable. Not to be overlooked is the fact that a living Trust is, generally speaking, free from attack by the creditors of your estate.

Now we come to our old friend "taxes" and their relation to the use of Trusts. The Trust may be used to exempt property from Federal Estate Tax and/or from our personal income tax. Let us examine a few ideas that may save you money.

CHARITABLE TRUSTS. Assume that you are in the 60% income tax bracket; that you wish to make a gift of income from securities to your favorite charity; that the securities will produce 3%; that you have $30,000 of these securities. You establish an irrevocable Trust for a period of ten

years with the income during that period to be paid to your charity. At the end of the 10-year period the Trust terminates and the securities go to your children and/or your wife. You may immediately deduct as a charitable contribution in the year of establishment of the Trust 29.1% of the value of the capital of the Trust, or $8730. In a 60% income tax bracket this is an immediate income tax saving of $5238. Had you kept the securities you would have realized net after taxes $360.00 a year for ten years, or a total of $3600.

If you have no children or heirs you may wish to create an irrevocable Trust which pays the income to you and your wife for life and upon the death of the last to survive distributes the corpus to a tax-free organization. The value of the charitable remainder interest, based on your ages, is currently deductible from your Federal income tax. You may establish such a Trust this year and each year hereafter to take advantage of the charitable deduction allowance of Internal Revenue Code Section 170.

FAMILY TRUSTS. Let us use the same idea for your wife and children. Assume you place $20,000 of securities in Trust for ten years for the benefit of your son; the corpus of $20,000 is to revert to you at the end of the 10-year period; the income is to be "distributed" by deposit in a savings account, savings bonds or life insurance premiums, to your son each year. The value of the gift to your son is 29.1% of $20,000, or $5820. You and your wife may jointly give anyone each year up to $6000 with no gift tax liability. The income on $20,000 at 3% is $600.00 a year. Your son has a personal exemption of $600.00. Result? Had you kept the securities you would have realized each year net after taxes, assuming a 60% income tax bracket, $240.00 a year for ten years. Disregarding the Trustee's fee, which would be nominal, your child has acquired $6000. This is a saving of nearly $3600.

RETIREMENT INCOME. Doctor "Y" establishes a short-term Trust for Mrs. "Y" with the proviso that the Trust income shall be accumulated by the Trustee for her benefit. At the end of ten years the Trust is to terminate and the securities revert to Doctor "Y". Again, assuming a 60% income tax bracket, and $30,000 of securities which show a 3% return, Doctor "Y" has given up a net spendable income of $360.00 a year for 10 years. The Trustee has a $100.00 exemption and his income tax bracket starts at the 20% level. His tax then would be 20% of $800.00, or $160.00 per year. Again disregarding the Trustee's fee, the net accumulation by the Trustee would amount to $7400. This is a saving of about $3800. If the wife has income producing property she may establish the Trust and the income may be used to buy annuities or to pay life insurance premiums on the life of Doctor "Y", or to purchase other securities. Because the gift is of a future interest, i.e. the income is not currently distributed, there is no $6000 exemption. However, the lifetime gift tax exemption of $30,000 is available.

As you can see from these examples, the Clifford Trust, or as it is more popularly known, the Short-Term Trust, as outlined in the Internal Revenue Code, Sec. 671 to 678, gives authoritative procedures for saving taxes. The possibilities are infinite. Your lawyer, on whose advice and counsel you should rely in all matters pertaining to Trusts, will be able to show you how this device may be used to your own and your family's profit.

MARITAL TRUSTS. The gold mine of Estate Planning is the Marital Deduction provision of the Internal Revenue Code, Sec. 2056. As you know, you may give up to one-half of your estate to your spouse and to that extent it is exempt from your Federal Estate Tax. The danger is that upon the death of the surviving spouse the entire property will be subject to

Federal Estate Tax in the survivor's estate. This may result in more tax being paid than had you given one-half of your property to your children and only the other half to your wife. The proper way to arrange your affairs if you want your wife to have the benefit of your entire estate is to give one-half of your estate to her outright and the other half in Trust for her benefit. The Trustee is authorized to distribute income and to the extent necessary in his sole discretion, corpus, to your wife for her maintenance, support and welfare. However, at her death that portion of your estate in Trust passes directly to your children and is not taxed in her estate. If this provision has not been included in your wills, I urge your prompt consideration of it.

—*William L. Spencer*

VD SEMINAR IN YOUNGSTOWN

The Postgraduate VD Seminar, to be held at the Mural Room morning and afternoon of Thursday, Sept. 24, is expected to attract large numbers of physicians from the Youngstown-Warren area.

Jointly sponsored by the Mahoning County Medical Society, the Mahoning Chapter of the American Academy of General Practice, and the local and State Boards of Health, the Seminar will present an outstanding panel of speakers.

Addressing the group will be Dr. Evan W. Thomas, formerly Consultant in Venereal Diseases, New York State Department of Health, Emeritus Professor of Clinical Medicine (Syphilology), New York University College of Medicine, and formerly Director of the Syphilis Service at the Bellevue Hospital in New York City.

His associate speakers will be Dr. Winslow Bashe, Chief, Division of Communicable Diseases, Ohio Department of Health; Dr. Joseph Portney, Chief, Immunoserology Unit, Venereal Diseases Experimental Laboratory, United States Public Health Service, Chapel Hill, North Carolina; and Dr. James D. Thayer, Chief, Biologic Studies Section, Venereal Disease Experimental Laboratory, United States Public Health Service, Chapel Hill, North Carolina.

Local speakers will include Dr. Leonard A. Blum, Commissioner of the Youngstown Department of Health, Dr. M. W. Neidus, President of the Medical Society, and Dr. Paul Krupko, President of the Mahoning Chapter of the American Academy of General Practice.

The course will offer postgraduate credit of 5 hours, Category I approved by the Ohio Academy of General Practice.

Registration at the Mural Room will open at 9:30 a.m. Dr. Neidus will preside over the morning session which will begin at 10:00. Luncheon will be served at noon. Dr. Paul Krupko, will preside over the afternoon session, beginning at 1:30 p.m. The seminar will adjourn at 4:00 p.m.

Reservations for those attending the conference should be made through the Mahoning County Medical Society office, phone RIverside 6-8431. Cost of the luncheon will be $2.25.

the cerebral level of serotonin, but did not appear to raise that of norepinephrine levels proportionately.
Pfizer's new drug overcomes this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.
The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.
The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

NIAMID* *the mood brightener*

FROM THE BULLETIN

Twenty Years Ago — September 1939

Society affairs always pick up speed in September. That year things seemed about as usual. From reading the Bulletin one would never know there was a bloody war brewing in Europe. A corn roast was announced for September, a dinner dance in October, and a banquet in December. The Doctors' Secretaries' Organization held their Harvest Moon Dance at the Mahoning Country Club and listened to the music of Ruth Autenreith's Orchestra. Dr. Walter Simpson addressed the Society on "Artificial Fever Therapy" which was a hot subject those days. Only one ominous note in the whole twenty-eight pages: Dr. Martin Conti closed his office and left for active duty in the United States Navy.

President Skipp proposed that we change our day off from Thursday to Wednesday so that we could all go to the meetings in Akron, Canton, New Castle, or Pittsburgh which are always on Wednesday. He got his way after a while and we did change. More about that later.

Dr. A. W. Miglets had a leading article on "Diarrhea". He divided the cases etiologically into mechanical, fermentative, infectious, and proteolytic. He stated that diarrhea was usually a protective mechanism to get rid of deleterious substances and stressed that replacement of fluid was the most important part of the treatment.

The Medical Crier wanted to know why so many children returned to school after their vacations rosy cheeked and healthy and immediately came down with severe respiratory infections.

Editor Patrick deplored the fact that the per capita expenses for public health activities in Youngstown was only twenty-five cents, while in Cleveland it was sixty cents. He noted with satisfaction that no expense had been spared to give us a good safe water supply from Meander Reservoir.

Ten Years Ago — September 1949

Editor Gustafson urged everyone to write Thank-You letters to Senator Taft and Bricker who voted against Truman's Welfare Plan. President McCann inveighed against laws legalizing euthanasia which were being proposed to state legislatures in different sections of the country. Skipp was campaigning for members in The World Medical Association, dues $10.00 a year.

Oscar Turner had a leading article on "The Diagnosis of Acute Poliomyelitis." He described many of the unusual or infrequent signs. Excerpts: "In very rare instances, severe cerebral involvement may cause a spastic rather than a flaccid type of paralysis". "Muscular paralysis is frequently preceded by a tremor of the extremity." "The earliest sign of paresis of the neck muscles may be manifested by an asymmetrical posturing of the head." "Frequent yawning in a child with poliomyelitis indicates a serious prognosis."

Former internes of St. Elizabeth's Hospital had a big day at their reunion. Dr. H. E. Clark from the New York Post-Graduate School spoke on "Management of Lesions of the Colon and Rectum". J. K. Herald of the Section on Proctology led the discussion. After an afternoon of golf, prize-winners were S. W. Ondash, Harold Reese, A. M. Marinelli, and D. R. Dockry. Door prizes went to W. Breesman, L. M. Shensa, and W. E. Maine. R. V. Clifford was president of the association.

Breesman and Fred Lamprich were internes then. Robert V. Bruchs, Dockry, and Leonard Caccamo were residents.

Harold Chevlen started practice of general medicine at 2004 Elm Street. George Cook came back from Pittsburgh to practice orthopedics. Clyde Walter reopened his office in Canfield after a cource in allergy in Chicago. Edward A. Shorten finished his reidency at the Youngstown Hospital and joined George McKelvey and Walter Turner in the practice of surgery. Dean Stillson finished his residency at the Youngstown Hospital and joined Lewis Reed in the practice of internal medicine.

Thus was the medical circulation in our district enriched by a transfusion of fresh young blood of quality.

—*J. L. Fisher, M.D.*

INCOME TAX DEDUCTIONS

A special ruling of the Internal Revenue Department concerning the deductibility for Federal income tax purposes of doctors' entertainment expenses is as follows:

1. A physician may deduct on his Federal income tax return the costs of entertainment, provided he can establish to the satisfaction of the Internal Revenue Service, by an appropriate evidence, that such expenses are ordinary and necessary business expenses and clearly related to the production of business income.

2. The amount of the deduction must be proven and its reasonableness determined. Once the amount is established, the deduction may be claimed when the doctor is able to show that the entertainment had a direct relationship to the conduct of his practice, and can show the business benefit reasonably to be expected from the expenditure. The general statement that he hoped or expected to get referrals or patients as a result of the entertainment is not enough. If personal reasons predominate, the expenditure may not be deducted, even though there is some possibility of a business benefit. Except in the case of industrial physicians, entertainment of individuals who are not doctors will not ordinarily qualify because the possibility of benefits to be expected are so remote as to be negligible. In instances of the entertainment of patients, the same general rules apply as in the entertainment of other doctors, and the clear relationship of the expenditure to reasonably expected income must be shown. The same rules also apply to civic and other club dues.

Criteria to be used in establishing the deductibility of entertainment expenses include, but are not limited to the following:

a. Specific purpose of the entertainment.
b. Nature of the practice of the doctor incurring the expenditure.
c. Period of time the doctor has been in practice and the number of patients he already has.
d. Percentage of his patients received as referrals.
e. Names of individuals entertained and reason why additional income could reasonably be expected from each.
f. Whether or not referrals were actually received from the doctors entertained and any indication of the effect of the entertainment on these referrals.
g. Number of times individual doctors were entertained during the year, inasmuch as repeated entertainment indicates a personal motive.
h. Whether or not other doctors in the same type of practice in the locality have entertainment expenses.

We trust that the above will be helpful in clarifying this area of tax law and administration.

ENDOTRACHEAL ANESTHESIA IN INFANTS & CHILDREN

In 1925 during the discussion of a paper on anesthesia in infants and children both Magill and Clausen expressed their regret that the advantages of endotracheal anesthesia were so seldom exploited in operations upon these patients. Probably at that time the chief reason was that in comparatively few of these operations was the technique required. Besides, endotracheal intubation is technically more exacting in the child than in the adult.

In recent years the use of endotracheal techniques for administration of general anesthesia to infants and children are becoming more commonplace, because more patients of this age group are now undergoing surgery and better anesthesia is needed for them.

Endotracheal anesthesia in infants and children is an extensive subject. This paper deals only with some of the anesthetic problems, techniques, equipment and general clinical application, which we find satisfactory in our daily practice at St. Elizabeth Hospital.

I. ANATOMICAL PROBLEMS AND GENERAL CONSIDERATIONS:

It is common knowledge to all trained anesthesiologists that most difficulties of intubation in infants and children originate partly from anatomical causes and partly from behavior of these patients toward general anesthesia. The glottis in the child is naturally small and it occupies a more cephalad and anterior position. The epiglottis is proportionately longer than that in the adult and appears to lie very close to the glottic opening. The protective reflex of the larynx is very irritable. At the level of the cricoid cartilage there is relative narrowing of the airway. Frequently prominence of the maxilla and retrusion of the mandible make direct laryngoscopy troublesome. The teeth-bearing margin of the maxilla is not resistent and can be easily indented by excess pressure during laryngoscopy. The deciduous teeth in children may be easily dislodged.

Ideal conditions for laygnoscopy cannot always be readily attained in infants, because whereas mandibular relaxation occurs early in anesthesia, the glottic reflex may still be present when the circulatory or respiratory system, or both, begin to show signs that the depth of anesthesia may not be tolerated. When laryngoscopy is undertaken in the presence of an active glottic reflex, it is often noticed that the glottis moves anteriorly with each breath and disappears from the field of vision. When the catheter is passed, the infant will often develop an intense respiratory spasm resulting in much anoxemia. Congenital anomalies, such as harelip, cleft palate and other pathological conditions which deform the anatomy of the air passages often render endotracheal intubation very difficult. In view of these factors endo-

tracheal intubation in infants and children should be undertaken with extreme gentleness and care.

II: INDICATIONS OF ENDOTRACHEAL ANESTHESIA:

Endotracheal intubation is always indicated whenever there is a need of maintaining a patent and clear airway, control of intrapulmonic pressure and the application of assisted or controlled respiration during the operation. For safe and satisfactory administration of general anesthesia for operative procedures performed on the head and neck, all intrathoracic procedures and procedures done in the lateral and prone positions endotracheal intubation is well indicated. Only in few instances we would substitute endotracheal anesthesia with the open-drop or insufflation technique of di-ethyl ether.

III. EQUIPMENT:

There is a great variety of laryngoscope blades and endotracheal catheters available in the market. We find the following equipment very satisfactory in our hands. For infants we use the infant Miller blade for direct laryngoscopy, for children up to five years of age we use the child size Flagg laryngoscope blade, and for children up to ten years of age the No. 2 Wis-Foregger blade is adequate. Frequently the straight Miller blade can be best used in the manner as a Macintosh blade in infants. This is preferable for reasons originally stated in the Macintosh technique, plus the fact that it is often difficult to lift the epiglottis in infants. We find the soft thin-walled Magill endotracheal catheters very satisfactory because they are pliable and thus cause little pressure to the delicate structures of the air passages. The plastic Murphy catheters are more suitable for certain cases in which acute flexion and rotation of the head during the operation pose the danger of kinking of the catheter. The latter possess the advantages of being less compressible and kinkable when acutely angulated and the presence of an additional side-opening at the distal end.

In view of the narrowing of the larynx at the region of the cricoid ring the author favors the selection of a catheter of proper size and length which will pass the larynx and trachea easily in order to avoid excessive pressure and subsequent edema. Any catheter that fits the larynx snugly will often be found to be too large to pass through the subglottic cricoid level. All endotracheal catheters are thoroughly cleansed with soap and water, sterilized in 0.1% aqueous Benzalkonium chloride solution and kept separaely for further use. Inflatable cuffs are not used in catheters for infants and children because they tend to encroach upon the lumen of them. As a lubricant we prefer the local anesthetic, Pramaxine, in water soluble base. In all cases of endotracheal intubation and with few exceptions we choose the oro-tracheal route because a larger catheter can be passed and unnecessary trauma to the nasopharynx can be avoided.

IV. INDUCTIONS AND MAINTENANCE OF ANESTHESIA:

Open drop di-ethyl either is generally the anesthetic of choice for induction and maintenance in infants. This is a slower but satisfactory technique for patients of this age group. In children over two years of age divinyl ether is substituted for induction. To achieve maximal muscular relaxation and obtundation of laryngeal reflex it is advisable to perform endotracheal intubation with the patient near third plane of ether anesthesia. For children over ten years of age we frequently use the rapid induction technique by administering a calculated dose of sodium thiopental and succinylcholine intravenously. These patients are all well oxygenated during the period of apnea prior to intubation. We prefer the open non-rebreathing endotracheal system for infants and children by attaching a Sander's or Turnbull's connector onto the

catheter for maintenance of anesthesia, because there is minimal accumulation of carbon dioxide over a long period of time and rapid denitrogenation of the lungs can be readily accomplished. To prevent lightening of anesthesia during intubation insufflation of ether can be instituted with a metal ether hook. Employing the to & fro or infant circle technique we have used cyclopropane as an induction agent in infants and children. For muscular relaxation a calculated dose of succinylcholine is given intramuscularly and indotracheal intubation performed with ease. This technique is less time-consuming and more pleasant to the children than the open-drop ether technique. Whenever there is the possibility of fire and explosion in the operating room, it is advisable to use a non-flammable agent for induction and maintenance of anesthesia. Halothane (Fluothane) a new volatile anesthetic agent meets this requirement and has been administered in the same manner with satisfactory results.

V. CONCLUSION:

The advantages of endotracheal anesthesia in infants and children outweigh its disadvantages when administered properly. Extreme gentleness in endotracheal intubation is mandatory in order to avoid the traumatic sequelae to the larynx. In the broad clinical experience being accumulated in the daily practice of pediatric anesthesia endotracheal intubation in infants and children has proven to be a very safe and rewarding technique.

—*C. C. Chen, M.D.*

AMA PUBLIC RELATIONS INSTITUTE

Socialized medicine came in for important consideration at the AMA Public Relations Institute held recently in Chicago and attended by Dr. L. S. Shensa and Mr. Howard Rempes. The entire morning of the first day was devoted to this subject.

A feature of the Institute, and one that was warmly applauded, was the appearance of two sixteen year old youngsters, 1959 Science Fair winners, who addressed the doctors. They were Miss Edith K. Schuele of Memphis, and Martin J. Murphy, Jr., of Colorado Springs, who impressed the assembly with their scientific achievements.

Highlight of the Chicago meeting was the premiere showing of a new film, "I Am a Doctor." Designed to tell young people something about a medical career, the movie goes much further and paints a dramatic picture of the doctor in today's society. The movie will soon be available for public showing.

Other sessions of the meeting were given over to various public relations projects undertaken by state and county societies. The Mahoning County representatives found that this society is well known at the AMA for its active public relations committee.

KOLMER WASSERMAN TEST REPLACED

Effective July 1, 1959, the Ohio Department of Health Laboratory will replace the Kolmer Wasserman test with the Reiter Protein Complement Fixation Test. (R.P.C.F.)

In principle the R.P.C.F. test utilizes as an antigen a protein fraction obtained from the Reiter strain of Treponema Pallidum.

The V.D.R.L. and Kline serologic tests will be performed routinely, and all specimens showing any reactivitiy will then be examined by the R.P.C.F. test.

It is believed a repeated reactive treponemal test is more specific evidence of treponemal infection than a repeated reactive standard serologic test using cardiolipin antigen.

Disagreements between the standard serologic tests and the R.P.C.F. may vary depending on the stage of the disease. Therefore, results of the R.P.C.F. like the other treponemal tests (TPI-TPCF) are not infallible and the final diagnosis is left to the attending physician.

Several investigators have shown that the results obtained with the purified Reiter protein antigen (Ryprogen) are comparable to those obtained with the expensive and difficult Treponema Pallidum immobilization test (TPI). It shows excellent sensitivity with a specificity of at least 98.9. Complement fixation tests with Ryprogen detect a higher percentage of primary and secondary syphilis cases than even the TPI test.

Results with the R.P.C.F. test compare favorably with those of the TPI, TPCF and Treponema Pallidum immune adherence test (TPIA), and are definitely superior to those obtained with the Mazzini, VDRL, Rein-Bossak and Kent cardiolipin complement fixation tests. The Public Health Service Venereal Diseases Laboratory in Chamblee, Georgia reported that in eight different laboratories, results with the R.P.C.F. test proved better than those obtained with the TPCF test and were comparable to those given by the TPI tests.

Ryprogen thus provides a highly specific, sensitive, economical convenient test for the diagnosis of syphilis. It may be employed in all laboratories, and because of its superiority, is recommended for routine general use in serological tests for syphilis.

A memorandum from the Venereal Disease Research Laboratory states that the TPI test can only be performed in the future if the following conditions are complied with.

1. Patient has had a spinal fluid test.
2. Has not previously been diagnosed as syphilis.
3. Had less than two recent blood tests.

4. A complete data sheet must accompany specimen.

In the future the Ohio Department of Health will only do the Kolmer Wasserman test on special request. Inquiries relating to the interpretation of serologic reactions may be directed to the Communicable Disease Division of the Ohio Department of Health.

—*L. A. Blum, M.D.*

IN MEMORIAM

DR. E. E. KIRKWOOD

1894 — 1959

Dr. Elmer E. Kirkwood, an Honorary Member of the Mahoning County Medical Society, died in Youngstown on August 14, 1959.

Dr. Kirkwood came to Youngstown in 1925 to take charge of the Mahoning County Tuberculosis Sanatorium while it was still under construction. He was with the sanatorium as Medical Director until 1946.

He established the first tuberculosis clinic in Youngstown, which is now in operation in the Dollar Bank Building.

Before coming to Youngstown, Dr. Kirkwood had made a name for himself in Cleveland, where he had introduced multiple shots for childhood diseases. He was an assistant at the Warrensville Sanatorium when he was offered the job of heading the proposed Mahoning County Sanatorium.

Dr. Kirkwood was born in Kirkwood, Mo., on May 7, 1894. The town was named for his family, which was among the pioneer settlers of the district. His pre-med schooling was at Missouri University. He graduated from St. Louis University School of Medicine. He interned at St. Louis City Hospital and took additional work at the Moberly General Hospital.

After leaving Youngstown, Dr. Kirkwood went to the University of Buffalo Medical School where he took refresher courses, then returned to Youngstown to establish private practice. He announced his retirement in October of 1958, and left with Mrs. Kirkwood for a visit to the San Fernando Valley in California.

Besides being a member of the Medical Society, Dr. Kirkwood was a member of the Ohio Chapter of the American College of Chest Physicians, of which he was a past president; the American Medical Association; Odd Fellows; Masons; and Trinity Methodist Church.

Dr. Kirkwood was known for his kindness to his patients and for his great zeal in carrying out an expansion program for the TB Sanatorium. As a Youngstown doctor, he added much to the medical story of Mahoning County.

MEDICAL GLEANINGS

POSTVIRAL MYOPERICARDITIS ASSOCIATED WITH THE INFLUENZA VIRUS

Crawford W. Adams, M.D., F.A.C.C. Nashville, Tennessee

The American Journal of Cardiology, July 1959

SUMMARY

Eight cases of acute benign "idiopathic" or "non-specific" pericarditis are reported in which an influenza virus was associated by history and serologic evidence with the acute pericarditis. The laboratory evidence demonstrated in five cases the type B (Great Lakes) influenza virus; in two cases both Type A (Japanese) and type B viruses; and in one case the type A virus.

Seven of the eight patients reported were males. There was an interval of one or more weeks between the acute episode of "influenza" or "upper respiratory infection" and the cardiac disorder.

Acute "nonspecific" pericarditis is not necessarily "benign," as it is frequently associated with myocarditis, pericardial effusion, pleurisy, pleural effusion, and pneumonia. These features may be more appropriately designated as acute myopericarditis.

All patients with "postpartal heart disease," atypical myocardial infarction, or acute "nonspecific" pericarditis should be carefully evaulated for the recent presence of viral diseases as a possible cause of the cardiac difficulty. The hemagglutination inhibition influenzal antibody titer determinations, an ancillary service of the state laboratory, are recommended in all cases of acute "nonspecific" pericarditis in an effort to further classify these cases.

The history and the clinical and laboratory findings in these eight cases of "non-specific" pericarditis suggest that this cardiac disorder is in fact a myopericarditis and the term postviral myopericarditis is suggested in preference to acute benign "nonspecific" or "idiopathic" pericarditis.

—*R. L. Jenkins, Jr., M.D.*

WANTED — MEDICAL WRITERS

Any member of the Mahoning County Medical Society who is interested in writing for the Bulletin next year is invited to contact the 1960 Editor, Dr. Jack Schreiber, LEnox 3-3351, or Mr. Howard Rempes, Executive Secretary, RIverside 6-8431.

WOMAN'S AUXILIARY NEWS

The opening meeting of the Auxiliary will be September 22nd at the home of Mrs. John Noll. All members are encouraged to attend. New members will be greeted and a panel discussion will be held on Para-Medical Education. This will include such workers as Medical technicians, medical secretaries, dieticians, physiotherapists, and medical record librarians.

—Mrs. Paul E. Ruth, Publicity Chairman

NEW HOSPITAL PUBLICATION

A new publication, as yet unnamed, has been launched at St. Elizabeth Hospital. Filling the need of a clearing house for hospital information, the mimeographed journal will report hospital activities and administrative policies to the staff members.

It is being put out by Mr. Fred Nebot, Director of Public Relations, and Dr. J. R. Sofranec, representing the Medical Staff.

The first issue came out on August 17.

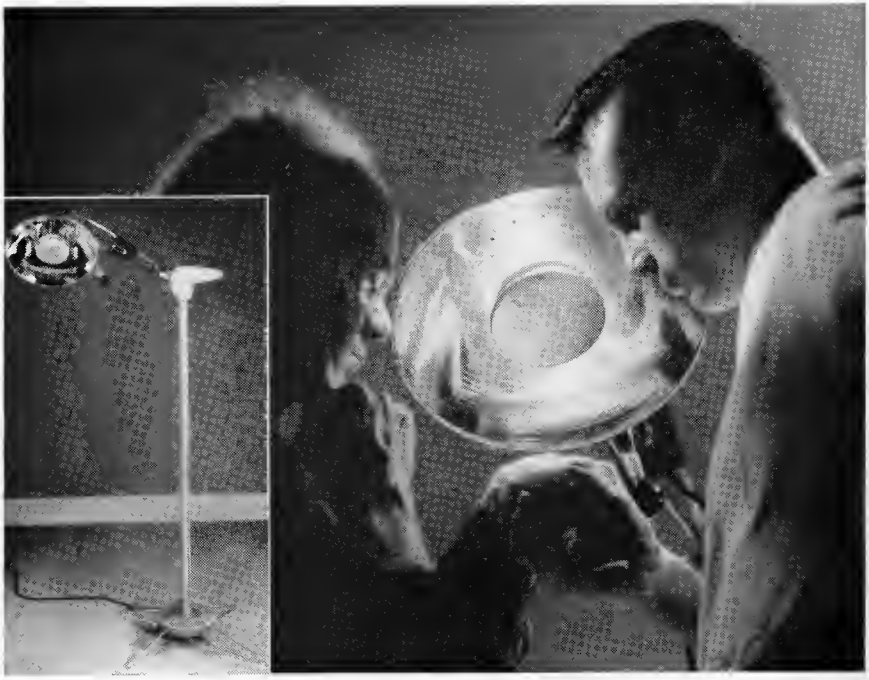
MEETINGS

AMERICAN COLLEGE OF GASTRONETEROLOGY, Biltmore Hotel, Los Angeles, September 19-26. Mr. Daniel Weiss, 33 W. 60th St., New York 23, N.Y., Executive Director.

AMERICAN COLLEGE OF SURGEONS, The Traymore Hotel, Atlantic City, N.J. September 28-October 2. Dr. Paul R. Hawley, 40 E. Erie St., Chicago 11, Director

CENTRAL ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS, Drake Hotel, Chicago, September 24-26. Dr. Edwin J. DeCosta, 104 S. Michigan Ave., Chicago 3, Secretary.

OHIO SOCIETY OF ANESTHESIOLOGISTS, Dayton Biltmore Hotel, Dayton, September 18-19. Dr. Nicholas G. DiPiero, 9710 Garfield Blvd., Garfield Hts. 25, Ohio, Secretary.



Put this NEW light in your office!

Castle, the first name in surgical lighting, announces a new light—the No. 8 M•P Light. With its new styling and with the features of higher-priced lights, it actually costs less.

It's modern in design. Lightweight. Moves easily up, down and around; beams light from every angle. Comes in COLOR.

Never before has such a fine light been available at such a low price. Call your dealer for a demonstration or write:

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